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ABSTRACT

Outreach counseling was offered to 83 veterans just returning from Vietnam and outcomes were compared with those of 68 matched controls. Capitalizing on the crisis or stress of the re-entry, service was offered to all veterans returning to Cleveland. Counselors' initial relationships with veterans tended to be built on short term assistance with concrete problems of adjustment; the overall objective, however, emphasized preventive mental health and growth. This two-part paper concentrates on operational difficulties encountered. The outreach counselor's role often entails pursuit of a reluctant but hurting client, and the uncertainty and frustration of this role may unduly center the counselor's attention on avoiding a breach in the relationship. To maintain contact with the client, counselors often emphasized tangible objective services (e.g. help with GI Bill) and avoided personal problems. Yet the outreach counselor, though avoiding personal issues, is in a unique position to observe the client's needs and problems, resulting in some conflict. Intensive training, support, and supervision are needed in carrying out the difficult but therapeutically powerful role of re-entry counselor. Some evidence was obtained to indicate that verbal facility and prior training in human relations were essential qualifications for counselors. (Author)

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Crisis Re-entry Counseling With Veterans Returning From Southeast Asia

Part I Description of the Program (A "handout" to accompany oral presentation)

ABSTRACT: This paper describes experience with a counseling service that can be offered at a crisis or transition point in the client's life: re-entry into his home community. An application of crisis theory, the approach utilizes outreach methods rather than regular institutional contacts. This "handout" describes the program. The oral presentation centers on the operational problems encountered, for the ability to anticipate such difficulties would be an asset to those contemplating the establishment of comparable programs.

The program has provided counseling to 83 veterans recently returned from Southeast Asia, plus about 25 pilot cases. Twenty-five of the 83 came to us as ex-heroin users who refused the offer of in-patient care at a VA Drug Unit. We have also seen and interviewed 68 control cases. Counseling sessions averaged one per week and were carried on in the client's home or "home turf" rather than in an institutional setting. The counseling program will be completed on about February 1, 1974 when 58 study cases and 68 controls will have been in the program for at least 8 months and will have had pre and post interviews. Additional means of evaluating the program will be drawn from work records and police reports.

The transition between military life and return home presents acute dilemmas for returnees, particularly those who adopted new patterns of alcohol or drug use. Drug use may have filled a need during military service, but may pose new problems at home. Correspondingly, the brief transitional period of re-entry presents some degree of crisis and decision for new veterans.

The first weeks at home are often unstable; major life systems and viewpoints are "unstuck" and thus relatively susceptible to influence or treatment. The returnee is urgently seeking to re-enter niches in his altered environment; his girlfriend may now be married to someone else and his closest friends may be gone. Re-establishing family relationships, making new social contacts; and obtaining economic support, all pose simultaneous demands for adjustment. Counseling offered at this time of vulnerability may be highly welcomed, an asset to effectiveness. Helping the client enter activities and participate effectively in a stable social network reduces the likelihood that he will seek entry into illegal activities or into the social and criminal networks of drug use. Direct family contacts were often utilized and brief family therapy occasionally improved functioning dramatically. There was a unique opportunity for occupational as well as personal growth. The counselor often acted as an advocate or a broker for community services. It is our experience that referrals to community agencies were most

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effective when the counselor prepared the client, creating a need for the service, and supervised the follow-up.

The counselors' strength derived in part from his capacity to provide immediate "on the scene" help with the many concrete problems that arise in re-adjustment: information from the army, about veterans benefits, and access to vocational services. Counselors became real persons within the client's social network. Further, counselors encouraged their clients to air their concerns at a time when there were many problems and few "understanding listeners." Some clients seemed to need an affectively thorough debriefing, in order to obtain "peace of mind" regarding drug or war experiences. Accordingly, the counselor soon earned the status of a genuine helper and as such was sometimes able to exert a strong influence toward constructive choices and coping behavior. The client was not handicapped (or driven off) by the negative identities implicit in the situation of hospital or corrective facility.

EXAMPLE OF COUNSELING TECHNIQUES EMPLOYED: "STRENGTHENING SELF CONCEPT" : Solution to problems of identity or self-concept were defined as central issues in counseling, pre-requisite to good social relations and career choice. (These techniques are drawn in part from the work of Norris Hansell: Casualty Management Method: An aspect of mental health technology in transition, Arch. Gen. Psychiat., 19: 281-9, Sept. 1968.)

Counselors were trained to observe and detect the client's "positive identity." The core elements of self esteem may be present only in "trace quantities" during a period of crisis or depression. Letting the client know that these positive characteristics are seen and appreciated, has quick (but not necessarily lasting) impact on the clients' feelings of self respect, as well as on the client's sense of closeness to the counselor. The counselor may also assemble in writing, an inventory of the client's cherishable characteristics to be "reflected back" at various strategic points in work with the client. Rogerian "reflecting back" was useful in dealing with resistances and in maintaining a de-briefing experience. Much role practice and support is essential in training counselors in the use of these techniques. Detecting "positive identity" (accurately) is particularly difficult. The counselor also deals with pathological or negative self concepts using some of the methods listed below:

(1) Help provide a sense of continuity between past life, and the cherishable activities and self concept of that period, and hopeful ideas about future adaptations. Break the tyranny of the present by providing this perspective. Note signs of cherishable elements that persist, even in trace quantities. Call them to client's attention.

(2) Because of shifting and flitting attention typical of crisis, client may not be able to maintain a picture of his capacities or objectives. Counselor helps by keeping an inventory of cherishable aspects. He may even identify "positive identities" that the client had never recognized in himself.

(3) Focus client's attention on aspirations and plans, and help create clear sense of self (counteracting diffuseness in his sense of identity).

(4) Current frustrations can be seen as common and normal reactions to a difficult situation. Weakness, uncertainty, uncontrolled anger or other frightening symptoms may be seen as sequels to overseas service.

(5) Failures are discussed. Counselor abstracts the client's standards of excellence which lead him to see the situation as a failure. These standards of excellence provide a sense of strength and impetus for forward motion. Presence of values and judgmental standards demonstrates that individual is capable of adapting in a difficult situation.

(6) Attack negative identities (crock, junkie, failure). As above, interpret as transitional and help activate positive aspirations and constructive behavior. Use abstractions of "standards of excellence."

(7) Identify areas in which client feels "different", past and present. Again, abstract positive standards.

(8) Discussing obstacles that prevented client from doing and being what he most wanted, can reveal drive, direction and positive identity.

EVALUATION OF COUNSELING INTERVENTION: The achievement of program objectives is assessed through a comparison of outcomes as between counseled cases and matched controls. The following types of criteria are being utilized:

A detailed pre-and post- counseling interview with psychological tests assesses personal growth as well as such indicators of re-entry adjustment as (a) employment status, (b) relationships in his social network, (c) presence of "problem behavior" and (d) client satisfactions with his situation. The interview also included several short tests such as the "Tennessee" and "Rosenberg Self-Concept Scales" and a psychosomatic symptom scale, which provide outcome data, and the Ammons Picture Vocabulary Test to permit sharpened inter-group comparisons.

The pre-counseling interview usually required 2½ to 4 hours for its administration, but was well tolerated in that it provided a desired debriefing experience for the veteran just back from the service.

Data on drug and alcohol use is sought on all cases. The relationship of the counselor to the client, often permits direct observation of drinking patterns and frank reports of drug and alcohol use and the problems this usage may entail. Records of arrests and convictions will be obtained for each client. Stability of adjustment is assessed using the following criteria: (a) changes of residence, (b) number of changes of job, and (c) maintenance of social relationships over a 6 month period.

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Crisis Re-entry Counseling With Veterans Returning From Southeast Asia *

Part II Problems in Carrying out the Program (Presented at APA, Montreal, August 27, 1973)

The crisis service we have developed for work with veterans from Vietnam has become an extremely exciting project and I would enjoy using my time just describing it to you. But our topic this morning is "evaluation", so I have condensed the description into a 3 page paper that has been distributed to your seats.

The last half page of Part I outlines the plan for evaluating overall effectiveness. (See Part I, p. iii) But this is not the type of evaluation I am going to talk about. Rather, we will focus on some operational problems encountered, insofar as these may apply to programs of similar service design. The data come from supervisory sessions with our staff, and from individual de-briefing sessions with each counselor about each client. To describe the operational problems, however, I must first tell you a little about the service design and its rationale. It assumes that the transition between military life and the return home presents acute dilemmas for returning veterans, especially for those who adopted new patterns of drug or alcohol use while away. Such drug use may have filled a need during military service, but may pose new problems at home. Further, the first weeks at home find the returnee trying to re-enter niches in his altered environment -- niches that may have begun to close behind him. For example, his girlfriend may now be going with someone else. So, the brief transitional period of re-entry presents some degree of crisis and decision for most new veterans. People are more vulnerable at such times, more receptive to new views, and more ready to try new behavior, than during stable periods. In short, this should be a good time to try some counseling. And this is what we have done with over 100 veterans just back from Southeast Asia. We have recently begun a similar project with 18 men freshly returning from the Ohio prison system. Both projects include series of matched control cases who received no counseling.

The counseling contact was designed to last 8 months with weekly outreach visits during the first 2 or 3 months - more or less frequently, depending on the individual's needs and the relationship established. By outreach, I mean that we met veterans on their home grounds or in a car, often meeting friends and family as well. We almost never saw veterans at the VA.

The real goal of the service was to prevent poor adaptations, and we believe we were successful in this, at least in part. But this brings us to the operational difficulties. For a preventive program of this sort requires that we seek out the client and offer him a service. Ordinarily, he is not looking for help. About half our clients were very suspicious about the offer of outreach help from the Veterans Administration. But they had heard of outreach work from insurance salesmen and assumed the counselor was some sort of "hustler". A few parents even refused to let the counselor see their son, until they had privately checked him out.

Most of the time, counselors were able to clarify their role satisfactorily, only to run into a more serious resistance: many veterans didn't want to become clients, even though they may have had severe problems. A few felt inducted unwillingly into an aversive sick role (precisely what we were trying to avoid!)

*This paper was presented under the title "Intervention as a Problem in Evaluation." It is accompanied by Part I, which describes the counseling program, but Part II can be read by itself. Parts I and II are based on a manuscript submitted to the J. of Drug Issues, to be published Fall, 1973

Some were willing to accept tangible objective services like help in applying for GI benefits, but resisted personal counseling. It is difficult to provide numerical figures on the extent of such refusals and partial refusals of service; for the counselors themselves, in a kind of anticipatory response, often restricted the range of services they offered. That is, some counselors deleted the more intrusive services as though they sought to avoid conflict with clients, whom they anticipated to be resistive to the idea of discussing personal issues such as loneliness, adequacy, sex, grief, drugs, etc. Some counselors even seemed to disavow the impulse to delve into personal content. In so doing, these counselors redefined their roles in 4 ways. They acted not as counselors, but rather as expeditors (for example helping arrange VA benefits), as advocates (presenting their clients' interests or complaints to relevant agencies), or as friends (socializing and directly alleviating loneliness). Two counselors reported keeping their roles undefined and flexible (describing themselves as just "Joe from the VA"), hoping to alter their roles gradually, as the client's readiness permitted. However, there is evidence that these role redefinitions were counter-productive although they reduced counselors' discomfort in the short run. Perhaps toward rationalizing their need to redefine and narrow the counseling role, some counselors found it useful to perceive professional counseling roles as hazardous to their relationships with clients. For example, the Rogerian technique of "reflecting back" was taught to counselors as applicable in dealing with clients' resistances and in promoting a full and emotional de-briefing of wartime or drug experiences. Some counselors used "reflecting back" well in training, but not in actual practice; they described it as a type of "professionalism" and less than 100% sincere.

Although about half the counselors did not seem to narrow their roles in this way, the counselors as a group, developed a consensus regarding certain principles and guidelines, which in effect, protected the deviating counselor and rationalized his conduct. For example, the following ideas were widely accepted and applauded in staff sessions: "Some clients just want to function on 2 cylinders and there's nothing we can do about it". Another such principle: "You can't give help if there is no call for help". Yet the program was designed explicitly to offer help to persons who might need it and not be aware that it was possible to receive help. For example, it was our objective to offer everyone help in ventilating (or de-briefing) troublesome military or drug experience, enhancing self esteem, and helping counteract apathy or a sense of diffuseness.

Despite outstandingly warm and close relationships between supervisory staff and counselors, there was in effect then, a kind of organized resistance to the counseling tasks. This probably reflected the great strain and difficulty attendant on the client-counselor relationship, peculiar to this kind of program. We concluded that explicit preparation for such strains should be built into the training program. That is, counselors needed more help in dealing constructively with client resistances, but also with their own resistances which may stem from the difficulty of outreach work in a re-entry crisis.

Most counselors felt guilty and unhappy about their counseling performances, a problem that was dealt with in formal and informal group sessions and in supervision. Four counselors found that the pressure lightened after they accepted second jobs in the human relations area - lifting the burden of satisfaction and self-esteem from one demanding job alone. In another, related

type of dissatisfaction, some of our counselors became unhappy with the passivity of listening, hearing, and reflecting, rather than diagnosing and advising in a more masterful way.

Despite the prevalence of these difficulties in delivering a counseling service, over half of the client-counselor contacts eventually blossomed into close and productive helping relationships (or were productive from the start). However, successful relationships did not appear to distribute randomly among the staff, so we attempted to identify the characteristics of effective counselors.

First, as regards the characteristics of all counselors, we attempted to screen for basic warmth, interest in people, and respect for the autonomy of others. We tried to acquire a varied group, including persons intimately familiar with the cultural backgrounds of our client groups. Four counselors were black and one was Mexican-American. One was an ex-juvenile delinquent gang leader, one an ex-con, and two were ex-addicts. Including the directors of the program, there were 18 counselors, but only 2 served full time. Five had bachelor's degrees and another 7 had pertinent graduate degrees. There was some turnover in the staff, and at any one time there were usually 12 to 14 persons. We found that age, and closeness to the clients' cultural group, were poor predictors of counseling effectiveness. Although we presumed that human qualities rather than academic preparation would be predictive of counseling ability, the amount of human relations or clinical training was indeed highly associated with ratings of counseling adequacy.

This association was not noted inductively but through correlational analysis. We obtained these statistical coefficients by asking each supervisor independently to rate each counselor on 3 characteristics:

1. effectiveness in applying program objectives comprehensively.
2. prior training in human relations skills, and
3. verbal facility

After pooling the 3 supervisors' ratings, we intercorrelated"effectiveness"and"training"and found the 2 measures to be essentially identical (r=.92). However, the supervisors themselves were included in this computation and had all rated themselves high on both variables, artificially enhancing the correlation coefficient. When we removed the 3 supervisors, the correlation was still extremely high (r=.89) indicating that a relationship existed between the 2 variables at lower magnitudes as well as higher ones. The suspicion of a "halo effect" remains, but is lessened somewhat by the fact that the supervisors were surprised by this correlation, and had not believed that training would be strongly predictive of effectiveness. Perhaps our selective procedures in hiring made it possible to observe these relationships by standardizing certain human attributes such as "warmth" which are vital in counseling and which might otherwise have provided important sources of variation.

Verbal facility also appears related to counseling effectiveness (r=.76). We are tempted to conclude that the complexity of the program's objectives and the difficulty of establishing counseling relationships unduly handicapped persons who lacked academic preparation and verbal facility. Examining this generalization, we hypothesize that willingness to take the risk of trying out various counseling transactions may be related to self-confidence about being able to meet the verbal demands of these transactions. Some training may be helpful in building verbal self-assurance, but remedial training in building the basic verbal skills may require long-term effort with minimal yields.

Several conclusions may be listed:

(1) The program provided help to some members of an alienated group that might otherwise receive little mental health servicing.

(2) The outreach re-entry counselor fills a powerful role. He can assess clients' needs and problems better than an institutionally based counselor who obtains his data from verbal reports. The outreach counselor can also gauge success more realistically.

(3) While his role appears therapeutically powerful compared to that of the institutional counselor, strains on the outreach counselor are enormous:

a) He is on his own in the field and must often make key decisions without the support and advice of colleagues.

b) Publicly recognized expectations about the role of an outreach counselor, and mutual rights and obligations of client and helper, (so clearly spelled out in the case of other professional relationships such as medical practice) are lacking. Hence clients and their families do not know what to expect.

c) Clients' resultant uneasiness may be interpreted by the counselor as deriving from his own failures or inadequacy.

d) The counselor's role, often involving active pursuit of a reluctant, but hurting client, entails numerous frustrations.

(4) For the outreach counselor, his own frustration and insecurity may make it difficult for him to function and take needed therapeutic risks:

a) He can become overly centered on the task of attracting the client and avoiding a breach in the relationship. Thus he may develop an exaggerated need to deliver tangible gifts such as the promise of job-finding help. Similarly, he may feel compelled to avoid "objectionable" personal areas.

b) Yet he is exposed to a wide view of the client's life and relationships, seeing his needs more clearly than can an institutionally based counselor. The discrepancy between these perceptions and his unobtrusive role can become painful.

c) Even when client's needs or calls for help become clear, the outreach counselor may be unable to break from these limitations of his role, making it difficult to deliver help.

(5) Continuing support and supervision are needed in carrying out the difficult role of the outreach counselor. Supervisors had to pay special attention to the counselor's blocks or hang-ups, attempting to detect such obstacles, and then to air and help resolve them. Considerable secondary counseling was sometimes required. The heavy investment we also made in therapeutic group work was an investment well made. Counselors needed personal support, examples of how it feels to be a client, and role models. In summary, more training was needed, and a longer period in which to develop counseling skills on the job.

(6) There is some evidence that verbal facility and prior human relations or psychological training are essential qualifications for counselors.

(7) The program is expensive. The cost for research and development, $1500 per case, could be cut to about $300 in a large scale service application. This expense could further be sharply cut if the service were set up to monitor a large population, refer most cases to VA Regional facilities, and offer intensive outreach help only when unmistakable signs of need appeared.

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